EXHIBIT 2

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., and DR. JILL MEADOWS. M.D., Petitioners, v. TERRY E. BRANSTAD ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Case No. AFFIDAVIT OF DANIEL GROSSMAN, M.D.

1. I am a Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF) and an obstetrician-gynecologist with over 20 years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I previously served as Vice Chair of the Committee on Practice Bulletins for Gynecology. I am currently Vice Chair of the ACOG Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association (APHA). Additionally, I serve as Director of Advancing New Standards in Reproductive Health (ANSIRH) at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. I am also a Senior Advisor at Ibis Reproductive Health, a nonprofit research organization. I am a liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015 I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific). My research has

been supported by grants from federal agencies and private foundations. I have published over 130 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal Contraception.

2. I have served as a medical expert in cases challenging medically unnecessary and targeted regulations of abortion providers, including in a case that was decided by the Iowa Supreme Court, *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine*, 865 N.W.2d 252 (Iowa 2015), which struck as unconstitutional rules that restricted the use of telemedicine for medication abortion.

3. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

4. An updated and current version of my curriculum vitae (CV), which sets forth my experience and credentials more fully, is attached to this declaration. My CV contains a complete list of the publications that I have authored or co-authored.

5. I submit this affidavit in support of enjoining enforcement of S.F. 471 ("Act"). I understand that the Act requires patients seeking an abortion to first have an ultrasound, receive certain state-mandated information, and wait at least 72 hours before returning for the procedure. In my opinion, this requirement will not enhance women's decision-making about abortion and will impose significant obstacles on them. These obstacles, in turn, will delay women, exposing them to unnecessary health risks and other harms, and will likely prevent some women from having an abortion at all.

6. The opinions in this declaration are based on my education, clinical training, experience as a practicing physician over the past twenty-three years, my own medical research, regular review of other medical research in my field, and attendance at professional conferences. The facts in this declaration are based on my personal knowledge.

Access to Legal Abortion is Vital to the Protection of Public Health

7. Women seek abortions for a variety of medical, familial, economic, and personal reasons. 59% of women who seek abortions are mothers who have decided that they cannot parent another child at this time,[1] and 66% plan to have children when they are older (and, for example, financially able to provide necessities for them, and/or in a supportive relationship with a partner so their children will have two parents).[2] Approximately one-third of women in this country will have an abortion in their lifetime.[3]

8. It is extraordinarily important for women to have timely access to legal abortion. Women of childbearing age who do not have access to the procedure face significantly increased risks of death and poor health outcomes.

9. While abortion is a safe procedure, the risks from abortion increase as the pregnancy advances. Thus, delaying abortions until later in pregnancy drives up the risk of complications.[4]

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[1] Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (May 2016).

[2] Stanley Henshaw & Kathryn Kost, *Abortion Patients in 1994-1995: Characteristics and Contraceptive Use*, 28 Fam. Plan. Persp. 140, 144 (1996).

[3] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358, 1365 (2011).

[4] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the*

10. When legal abortion is unavailable or difficult to access, some women turn to illegal, and unsafe, methods to terminate unwanted pregnancies.[5] Other women, deprived of access to legal abortion, forego the abortions they would have obtained if they could have and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth,[6] and they and their newborns are at risk of negative health consequences, including reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes.[7] Women forced to carry an unwanted pregnancy to term also may find it harder to bring themselves and their family out of poverty.[8] And women

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United States, 103 Obstetrics & Gynecology 729, 735 (2004).

[5] Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reproductive Health Matters 136 (2010); Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 73 (2014); Tex. Pol'y Eval. Project, Research Brief: Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options (Nov. 17, 2015), https://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf.

[6] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[7] AP Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson, Michael A. Koenig, & Michelle J. Hinden, *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18 (2008).

[8] Ushma D. Upadhyay, M. Antonia Biggs & Diana Greene Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (2015); Am. Pub. Health Ass'n (APHA) Annual Meeting and Expo, Session 4150, Invited Panel: The Turnaway Study: Experiences of Women and Children Following Abortion and Denial of Abortion (*see especially* Diana Foster et al., *Effect of Being Denied a Wanted Abortion on Women's Socioeconomic Wellbeing* & Diana Foster, Sarah Raifman, & M. Antonia Biggs, *Effect of Abortion Receipt and Denial on Women's Existing and Subsequent Children*), https://apha.confex.com/apha/144am/meetingapp.cgi/Session/49007.

who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, and legal ties with that partner).[9]

11. Women in Iowa and elsewhere have limited access to abortion care because of a combination of state restrictions and limited provider availability. Even though advanced practice non-physicians can safely provide medication abortion and early surgical abortion, Iowa law prohibits them from doing so.[10] PPH uses telemedicine to connect their physicians with patients in some outlying areas where they operate clinics, but even with this service, 89% of Iowa counties still lack a provider, and 42% of women live in these counties.[11]

12. Women seeking an abortion also face significant personal obstacles. Most are below or close to the poverty line and therefore struggle to pull together the resources to take time off from work and arrange transportation.[12] One study from Arizona, before that state's mandatory delay law went into effect, found that "the majority of women seeking abortion care had to forego or delay food, rent, childcare, or another important cost to finance their abortion."[13]

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[9] Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (2014).

[10] Sharmani Barnard et al., *Doctors or Mid-Level Providers for Abortion*, 7 Cochrane Database Syst. Rev. CD011242 (2015); Iowa Code Ann. § 707.7; *see also* Guttmacher Inst., Overview of Abortion Laws (2017), https://www.guttmacher.org/print/state-policy/explore/overview-abortion-laws.

[11] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability In the United States, 2014*. 49 Persp. Sexual & Reproductive Health 17, 23 (2017); *see also* Guttmacher Inst., State Facts About Abortion: Iowa (2017), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-iowa.

[12] Jerman, Jones, & Onda, *supra* note 1, at 11 ("75% of abortion patients are low income, having family incomes of less than 200% of the federal poverty level.")

[13] Deborah Karasek, Sarah C.M. Roberts, & Tracey A. Weitz, *Abortion Patients' Experience and Perception of Waiting Periods: Survey Evidence Before Arizona's Two-visit 24-Hour Mandatory*

13. As noted above, most of these women are already parents (many have multiple children), and therefore need to organize and/or pay for additional childcare when they have health care visits. Many have inflexible work schedules and must work within narrow time constraints to arrange appointments. Still others must conceal these arrangements from abusive or controlling partners or family members.[14]

14. It is important to consider new abortion restrictions in this context: access to abortion is important to public health, and it is already limited.

Abortion Methods

15. In the United States, there are generally two methods of performing abortion: medical, by administering certain drugs, or surgical, using various methods depending on the gestational age of the fetus. This former method, which is known as a "medical" or "medication" abortion and which I refer to here as "medication abortion," is generally only available through 70 days after the first day of the woman's last menstrual period (LMP) or through ten weeks of pregnancy.

Waiting Period Law, 26 Women's Health Issues 60, 64 (2016).

[14] *See* ACOG, *Comm. Op. No. 554: Reproductive & Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013); Jerman, Jones, & Onda, *supra* note 1, at 7; Rachel K. Jones, Lawrence B. Finer, & Susheela Singh, Guttmacher Inst., *Characteristics of U.S. Abortion Patients, 2008* at 8 (May 2010), https://www.guttmacher.org/sites/default/files/report_pdf/us-abortion-patients.pdf (61% of abortion patients surveyed already had children, and 34% had two or more); Michael Lupfer & Bohne Goldfarb Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plan. Persps. 75, 76–77 (1981) (describing problems with delay, including increased expenses and missing additional time at work); Karasek, Roberts, & Weitz, *supra* note 13, at 62–63 (31% reported compromised confidentiality because they had to tell someone they did not want to tell); Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1 (2016); *see also* Sanders et al., *infra* note 28.

16. Medication abortion involves safely and effectively terminating a pregnancy non-surgically, through a combination of two prescription drugs: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. Medication abortion requires no anesthesia or sedation.

17. Surgical abortion involves the use of instruments to evacuate the contents of the uterus. Whereas first-trimester surgical abortion is generally a simple procedure lasting five to ten minutes, the method becomes longer and more complex later in pregnancy. Unlike medication abortion, surgical abortion often involves sedation and, in rare cases, involves general anesthesia.

18. A significant percentage of eligible women choose a medication abortion. In fact, in Iowa, the state's vital statistics report for 2015 states that 55% of the abortions performed that year were medication abortion.[15]

19. My own research in Iowa has documented that most women who choose a medication abortion have a strong preference for this method.[16]

20. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing.

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[15]Iowa Dep't of Pub. Health, Bureau of Health Statistics, 2015 *Vital Statistics of Iowa* 131 (last revised Mar. 7, 2017), https://idph.iowa.gov/Portals/1/userfiles/68/HealthStats/vital_stats_2015-20170307.pdf.

[16]Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (Aug. 2011).

21. Some women choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

22. For other women, there are medical reasons why medication abortion is better for them than surgical abortion. Some women have medical conditions that make medication abortion a significantly safer option, as it has a lower risk of both complications and failure than surgical abortion. These conditions include anomalies of the reproductive and genital tract, such as large uterine fibroids, female genital mutilation, vaginismus, or cervical stenosis, as well as severe obesity or an extremely flexed uterus, all of which make it difficult to access the pregnancy inside the uterus as part of a surgical abortion.

23. For these reasons, it is important to public health that women seeking an abortion are able to access care as early in their pregnancy as possible, when it is safest and, in many cases, when they have the option of avoiding surgery.

Mandatory Delay Laws Do Not Enhance Decision-Making

24. I treat patients in California, which does not require a delay period before patients can access abortion.

25. Before I initiate an abortion procedure, whether medical or surgical, I screen patients to make sure they are making a voluntary, informed decision. Because of this process, I am very familiar with how patients come to their decision to terminate a pregnancy. In my experience, women take the decision seriously, and they have gone through a meaningful

decision-making process before coming to the clinic. They have carefully considered their own situation, values and goals and consulted important people in their lives.

26. By the time they come to the clinic where I practice, most patients are firm in their decision to terminate their pregnancy. All patients meet with a counselor to review their decision, and some require additional counseling to help with their decision-making. If a patient is still undecided at the end of this process, we advise her to take more time with the decision, and to consult with others if she is comfortable doing so. That is standard practice and the standard of care among abortion providers.

27. Thus, based on my years of clinical experience, I do not believe women need to be forced to wait at least 72 hours after an ultrasound in order to make careful decisions about their pregnancy. To the contrary, such a blanket requirement trivializes the process women have already gone through and the firm decision they have made by the time they come to the clinic.

28. Research on mandatory delay laws in other states also indicates that these laws do not enhance decision-making. To begin with, research shows that, as in my clinical experience, the vast majority of patients are firm in their decision by the time they arrive at the clinic.[17] In fact, one study found that abortion patients were as or more certain of their decision than patients presenting for various other procedures or treatments, such as mastectomy after a breast cancer diagnosis, prenatal testing after infertility, antidepressant use during pregnancy, reconstructive

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[17] Mary Gatter et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81, 82–83 (2014) (finding that, when asked "How do you feel about your decision," 85.4% of patients responded that they felt confident and clear); Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 Persp. on Sexual & Reprod. Health 179, 182 (2016) (71% of patients reported low levels of decisional conflict).

knee surgery, or prostate cancer treatment options.[18] In another longitudinal study of almost 700 abortion patients, over 99% reported that abortion was the right decision for them when asked at several time points over three years after the procedure.[19]

29. I am currently involved in research looking at the effects of Texas's state-mandated ultrasound and *24-hour* mandatory delay law. Under Texas law, providers must not only offer to show the patient the ultrasound image and sound, but also describe the ultrasound to her. As part of this research, we surveyed patients at a number of clinics after their initial visit. Although we have not yet published these data in final form, the data indicate that this visit does not affect patient certainty; 92% had medium-high confidence in their decision about the abortion before the ultrasound, and the same percentage had medium-high confidence in their decision after.[20]

30. Roberts et al. found similar results looking at patients subjected to Utah's 72-hour mandatory delay law. Specifically, the percentage of women who came to their first visit with a low level of uncertainty and nonetheless continued their pregnancy after the delay period (2%) was "in the range of the proportions found changing their mind (1–3%) in settings with no or minimal waiting periods."[21]

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[18] Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 Contraception 269, 276 (2017).

[19] Corinne Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS One 1, 1 (2015).

[20] Tex. Pol'y Evaluation Project, *Impact of Abortion Restrictions in Texas: Research Brief* (Apr. 2013), https://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf.

[21] Roberts et al., *supra* note 17, at 185.

31. These studies indicate that mandatory delay laws do not dissuade women from seeking an abortion, which is not surprising to me, since as indicated above, they *already* deliberate and consider their options before scheduling the procedure.

32. A study by Gatter et al. looked at decisional certainty among women seeking an abortion at a Los Angeles clinic and also at decision-making about whether to view the ultrasound. In this study, patients were scheduled for an ultrasound and an abortion on the same day, and they were asked beforehand whether or not they wanted to view the ultrasound. A majority of patients chose not to view the ultrasound (which is my experience as well), and 98.8% of women went forward with the abortion after the informed consent process. Among the 85.4% of patients with follow-up data and reporting high decisional certainty, there was no association between the decision to view the ultrasound and the decision to continue a pregnancy (patients opting to view the ultrasound were just as likely to terminate their pregnancy as patients opting not to).[22] Among the small minority of patients reporting medium or low decisional certainty (7.4%)[23], there was an association with continuing the pregnancy. However, because the patients were not randomized to whether or not they viewed the ultrasound (it was their choice), the association may have appeared because, within the broad category of patients with "medium or low decisional certainty," women who were more inclined to continue their pregnancy (regardless of whether or not they viewed the ultrasound) may have been more likely to choose to view the ultrasound.

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[22] Gatter et al., *supra* note 17, at 83–84.
[23] *Id.*

33. In short, the overwhelming majority of patients arrive at their appointment certain in their decision without a state-mandated delay period. Providers are trained to screen for uncertainty, and the standard of care is not to proceed with an abortion if the patient is uncertain but rather to advise her to take more time with her decision. This is the best approach, clinically, to ensure that women who are firmly decided receive prompt care, and women who are not receive the support they need to reach a firm decision.

34. An additional problem with the Act is that it requires providers at the initial visit to inform patients of "indicators" and "contra-indicators." These are not medical terms, and I have never seen them before. In my opinion, providers will not know what information they need to give in order to comply with this requirement.

Mandatory Delays Burden Patients

35. Research also indicates that requiring patients to make an additional trip to the clinic and then wait a specified time period before having an abortion makes it harder for them to access this care. The Act is a particularly burdensome version of this requirement; if it stays in effect, Iowa will be one of only three states (joined by Missouri and South Dakota) that requires an in-person visit and 72-hour wait.[24]

36. To begin with, patients overwhelmingly do not want these requirements. In one study surveying 379 Arizona patients, 88% of patients expressed a preference for being

[24] Guttmacher Institute, *Counseling and Waiting Periods for Abortion* (Apr. 1, 2017), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion. This chart lists Utah in this category. However, Utah does not require an ultrasound or an in-person meeting for the first encounter (so long as the patient and provider meet "face-to-face," which includes via teleconference from the patient's home), so Utah does not in fact require two trips.

counseled and having an abortion on the same day, with only 12% preferring to have these visits on different days.[25] The 88% who preferred same-day care were significantly more likely than the other group to say that a mandatory delay would prevent their support person from accompanying them and also that they would travel out of state to avoid such a requirement.[26]

37. One recent study looking at Utah's 72-hour mandatory delay law found that the requirement imposed substantial burdens on patients. For example, patients were delayed an average of eight days, generally due to logistical reasons (as opposed to needing more time to come to a final decision).[27] As set forth above, this degree of delay prevents some women from having a medication abortion and exposes all women to the increased medical risk associated with delay. This finding has particular significance for Iowa, where medication abortion is available in eight towns and cities, while surgical abortion is only available in two out of the eight.

38. Notably, a small number of patients in the Utah study were still seeking abortions three weeks after their initial visit, one patient had been pushed past her provider's gestational age limit, and at least one patient had been pushed past the point in her pregnancy when she felt comfortable terminating.[28]

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[25] Karasek, Roberts, & Weitz, *supra* note 13, at 64.

[26] *Id.*

[27] Roberts et al., *supra* note 17, at 184.

[28] *Id.* at 179, 183.

39. This study found other burdens as well. Patients faced increased costs and diminished confidentiality. Women with pregnancy-related illness or symptoms had to endure these for an additional period.[29]

40. Women also reported significant stress associated with the delay along with a feeling of powerlessness and fear that they would lose desired medical options (such as non-surgical abortion).[30] That is consistent with my decades of clinical experience: patients are often anxious to terminate their pregnancy for various reasons. Some are experiencing debilitating pregnancy symptoms, such as intense nausea, or have a condition that may be exacerbated by pregnancy, such as hypertension. Some need to conceal the pregnancy and abortion from a coercive or abusive partner or family member, or from others in their community. Some are survivors of rape, and are particularly anxious to terminate their pregnancy because it is a constant, invasive reminder of that traumatic experience.[31] And some who are certain about their decision are nonetheless anxious about the abortion process itself; this can be especially acute for women who have a history of physical or sexual abuse or a past traumatic medical experience.

41. The Utah findings also are consistent with my current research in Texas, where 31% of women reported that the mandatory delay had a negative effect on their emotional well-

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[29] *Id.* at 183–84; *see also* Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 Women's Health Issues 483, 485 (2016) (62% of patients reporting negative effects from the mandatory delay, including lost wages, transportation costs, and having to disclose their situation to others they did not want to involve).

[30] Roberts et al., *supra* note 17, at 184.

[31] In addition, the many logistical difficulties of arranging a separate visit to the provider, including taking time off from work and/or school, arranging child-care, and making the necessary travel arrangements, are likely to be even more difficult for a woman following a traumatic event such as a rape.

being, and 23% found it difficult to get to the clinic for the consultation visit.[32] In a multivariable analysis, women below federal poverty guidelines were significantly more likely to report difficulty getting to the clinic. Patient costs associated with that extra, medically unnecessary visit averaged $141.[33]

42. These recent data confirm earlier research finding that mandatory delay laws severely burden women seeking an abortion. Studies of Mississippi's two-trip, 24-hour mandatory delay law found that, after that law went into effect, not only did abortion rates decline in that state, but the incidence of second-trimester abortion increased significantly (without increasing in neighboring states without such a requirement), as did the number of women traveling out of state to access abortion.[34] A 2009 review of that and other research concluded "that mandatory counseling and waiting period laws that require an additional in-person visit before the procedure likely increase both the personal and the financial costs of obtaining an abortion, thereby preventing some women from accessing abortion services," and also that "[i]f neighboring states have similar laws, so that access to an abortion provider who does not require this strict form of waiting period requires extensive travel, then such laws are

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[32] *Impact of Abortion Restrictions in Texas: Research Brief*, *supra* note 20, at 1; Daniel Grossman et al., *Impact of Restrictive Abortion Law on Women in Texas*, 88 Contraception 434 (2013) (abstract).

[33] *Id.*

[34] Theodore Joyce, Stanley K. Henshaw, & Julia DeClerque Skatrud, *The Impact of Mississippi's Mandatory Delay Law on Abortions and Births*, 278 J. Am. Med. Ass'n 653 (1997); Ted Joyce & Robert Kaestner, *The Impact of Mississippi's Mandatory Delay Law on Timing of Abortions*, 32 Fam. Plan. Persp. 4 (2000).

likely to lower abortion rates, delay women who are seeking abortions and result in a higher proportion of second-trimester abortions."[35]

43. In light of this evidence, the American College of Obstetricians and Gynecologists, the leading professional medical group devoted to the care of women, has recognized that multi-trip mandatory delay laws impose burdens on women and reduce their access to care, and that these laws therefore are "harmful to women's health."[36]

44. In addition to these concerns, I am particularly worried about the impact of the two-trip, 72-hour mandatory delay on Iowa women in rural and outlying areas. Until PPH began using telemedicine to provide medication abortion in these areas in 2008, women had to travel far distances—in some cases hundreds of miles—to reach a clinic in Des Moines or Iowa City with a physician present. Because of telemedicine, these women now have far more access, but only in the first 10 weeks of their pregnancy. Because women often do not become aware that they are pregnant until about 5 weeks LMP or later, many women struggle to access care within that 10-week period. An extra trip to the clinic and a 72-hour mandatory delay (which in practice often amounts to a delay of more than a week) will push many of these women past that window; not only will they lose the option of a non-surgical procedure, but they will have to travel much farther to receive care.[37]

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[35] Theodore J. Joyce et al., Guttmacher Inst., *The Impact of State Mandatory Counseling and Waiting Periods on Abortion* at 15 (2009), https://www.guttmacher.org/report/impact-state-mandatory-counseling-and-waiting-period-laws-abortion-literature-review.

[36] ACOG, *Comm. Op. No. 613: Increasing Access to Abortion* (Nov. 2014, reaffirmed 2017), http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20170412T1753496343.

[37] Roberts et al., *supra* note 17, at 184 ("Women who had an abortion waited about eight days between the information visit and the abortion.")

45. Research indicates that these distances are an additional barrier to care, pushing women further into their pregnancy, when abortion is less safe and more expensive. A study of abortion in Washington state found that rural women who had to travel more than 75 miles to obtain an abortion were two to three times more likely than women travelling less than 75 miles to terminate after 12 weeks, and that after abortion became less available in Washington, "the proportion of rural women having their abortions at later than 18 weeks more than doubled . . . growing from 2% to 5%," and the proportion of rural women having abortions after 18 weeks was "significantly higher than that among their urban counterparts."[38] In our research in Texas, we found that when clinics closed, there was a significant association between increasing distance to the nearest clinic and decline in the number of abortions, demonstrating how geographic barriers prevent women from obtaining care.[39]

46. For some women, the delay required by the Act will push them entirely out of the window in which they can access an abortion in Iowa at all (particularly given the new 20-week ban Iowa has enacted), forcing them to travel out of state to have an abortion, if they have the resources to do so. For others, it will force them to carry to term or to take potentially dangerous measures to self-abort.

47. I understand that the Act contains no exceptions other than for a medical emergency, which I understand is defined elsewhere as a physical condition that either poses a

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[38] Sharon A. Dobie et al., *Abortion Services in Rural Washington State, 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Fam. Plan. Persp. 241, 243 (1999); *see also* Joyce, Henshaw, & Skatrud, *supra* note 34.

[39] Daniel Grossman et al., *Change in Distance to Nearest Facility and Abortion in Texas, 2012 to 2014*, 317 J. Am. Med. Ass'n 437 (2017).

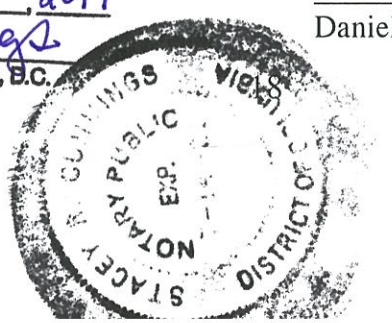
threat to the patient's life or "will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." Iowa Code § 146B.1(6) (2017). In my opinion and based on my experience, this exception does not begin to encompass the situations in which a 72-hour mandatory delay, in combination with a 2-trip requirement, would pose a particularly extreme hardship for a woman seeking an abortion. As noted above, some women need immediate care without unnecessary additional trips to the clinic, either because they are sick (but not in such a way that a major bodily function is about to be irreversibly impaired), or because their pregnancy is the result of rape and is itself traumatic, or because they are in danger of abuse if a partner or family member discovers their pregnancy.

48. I have also treated patients who made the painful decision to terminate a wanted pregnancy after discovering a serious fetal anomaly, including an anomaly that would have made the fetus unable to survive to term or after birth. I understand the law would require these patients not only to make an extra trip and then wait at least three days, but also to be counseled about "the options relative to pregnancy, including carrying to term." Iowa Code § 146A.1(1)(d)(a). This requirement will cause gratuitous pain to patients who are already grieving. It goes against the ethic of compassionate care that is central to the medical profession.

49. For all of the foregoing reasons, the Act will not improve women's decision-making about abortion, and will significantly burden them, diminish their access to care, and expose them to increased medical risk.

Signed this 26th day of April, 2017.

District of Columbia: SS
Subscribed and sworn to before me, in my presence,
this 26th day of April, 2017
Stacey R. Cummings
Stacey R. Cummings, Notary Public, D.C.
My commission expires July 14, 2021.



Daniel Grossman, MD

EXHIBIT A

April 1, 2017

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Current position

Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Director, Advancing New Standards in Reproductive Health (ANSIRH)

Education

Sept. 1985-May 1989	Yale University-Molecular Biophysics and Biochemistry	B.S., 1989
Sept. 1989-June 1994	Stanford University School of Medicine	M.D., 1994
June 1994-June 1998	Resident and Administrative Chief Resident, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	

Licenses/Certification

1996-Present	California medical licensure (A60282)
2001-Present	Board-certified, American Board of Obstetrics and Gynecology

Principal positions held

Aug. 1998-Feb. 2003 Aug. 2005-2012	Physician, St. Luke's Women's Center, San Francisco, CA
May 2003-Aug. 2005	Health Specialist, The Population Council Regional Office for Latin America and the Caribbean, Mexico City
Aug. 2005-Aug. 2015	Senior Associate (through June 2012), Vice President for Research (starting July 2012), Ibis Reproductive Health
Sept. 2015-Present	Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Sept. 2015-Present	Director, Advancing New Standards in Reproductive Health (ANSIRH)

Other positions held concurrently

Aug. 1998-Feb. 2003	Director of Medical Student Education, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Feb. 2003	Vice Chair, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-2015	Assistant Clinical Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
2012-2015	Contract physician, Planned Parenthood Shasta Pacific
Aug. 2015-Present	Senior Advisor, Ibis Reproductive Health

Honors and awards

1988 Howard W. Hilgendorf Jr. Fellowship, Yale University
1988 Robin Berlin Memorial Prize, Yale University
1989 Magna cum laude, Yale University
1990 Medical Scholars Award, Stanford University
1990 Peter Emge Traveling Fellowship, Stanford University
1991-1992 Foreign Language and Area Studies Fellowship, Stanford University
1994 Dean's Award for Research in Infectious Diseases, Stanford University
2007 Ortho Outstanding Researcher Award, Association of Reproductive Health Professionals
2009 Visionary Partner Award, Pacific Institute for Women's Health
2010 Scientific Paper Award, National Abortion Federation
2013 Gerbode Professional Development Fellowship
2013 Abstract selected as one of Top 4 Oral Abstracts at North American Forum on Family Planning
2013 Felicia Stewart Advocacy Award from the Population, Reproductive and Sexual Health Section of the American Public Health Association

Key words/areas of interest

Abortion, medication abortion, second-trimester abortion, contraception, over-the-counter access to oral contraception, integration of family planning into HIV care and treatment, Latina reproductive health in the US, misoprostol and self-induction of abortion, Mexico, Peru, Bolivia, Dominican Republic, South Africa, Kenya

PROFESSIONAL ACTIVITIES

PROFESSIONAL ORGANIZATIONS

Memberships

2000-Present: Fellow, American College of Obstetrics and Gynecology (ACOG)
2006-Present: Fellow, Society of Family Planning
2004-Present: American Public Health Association
2013-2015: American Medical Association
2004-2011: Association of Reproductive Health Professionals
2004-2016: International Consortium for Medical Abortion
2006-Present: Liaison Member, Planned Parenthood Federation of America National Medical Committee
2005-Present: Consorcio Latinoamericano contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion)
2004-Present: Working Group on Oral Contraceptives Over-the-Counter

Service to professional organizations

2008-Present: Society of Family Planning, reviewer of grant proposals, abstract reviewer for annual meeting
2007-Present: American Public Health Association, Governing Councilor (2007-2009, 2010-2014), Section Secretary (2008-2009), abstract reviewer for annual meeting
2005-2012: Consorcio Latinoamericano contra el Aborto Inseguro, member of Coordinating Committee

2006-Present:	Working Group on Oral Contraceptives Over-the-Counter, working group coordinator and member of steering committee
2010-2013:	Member, Committee on Practice Bulletins-Gynecology, ACOG
2014-Present:	Member, Committee on Health Care for Underserved Women, ACOG (Vice Chair of Committee starting May 2016)
2010-2016:	Steering Committee member, International Consortium for Medical Abortion
2016	External advisor for Marie Stopes International research strategy meeting, March 23-24, 2016, London, UK

SERVICE TO PROFESSIONAL PUBLICATIONS

2013-Present	Editorial Board, Contraception
2004-Present	Ad hoc reviewer for Obstetrics and Gynecology (10 papers in past 5 years), American Journal of Public Health (4 papers in past 3 years), Reproductive Health Matters (6 articles in past 4 years), Expert Review of Obstetrics and Gynecology (3 review in past year), and Women's Health Issues (4 articles in past 2 years), Lancet (2 reviews in past year)

INVITED PRESENTATIONS (Selected)

International

Second-trimester abortion. Optimizing the Potential for Medication in Pregnancy Termination in South America Conference, Lima, Peru, 2014 (invited talk).

Participation in panel at Harvard University seminar: Politics, Public Health, and Abortion: Examining the Changing Legal Environment in Mexico and Central America, Cambridge, MA, 2014 (invited talk).

Evidence for removing the prescription barrier to hormonal contraception. Annual meeting of the Associacion Française pour la Contraception, Paris, France, March 2015.

Presentations on medical abortion and second-trimester abortion, REDAAS (Red de Acceso al Aborto Seguro) meeting, Buenos Aires, Argentina, May 2015 (invited talk).

Panel participant in panel "Gestational limits for abortion: what purpose do they serve?" and presentations on adolescent pregnancy, telemedicine provision early medical abortion, and second-trimester abortion. Fifth Research Meeting on Unintended Pregnancy and Unsafe Abortion, Mexico City, September 2015 (invited talks).

Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. The Human Right to Family Planning Conference, Seattle, WA, October 2015 (invited talk).

Over-the-counter access to hormonal contraception- what are the risks and benefits?, and Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. XXI FIGO World Congress of Gynecology and Obstetrics, Vancouver, Canada, October 2015 (oral presentations).

Second-trimester abortion. Presentation at the First Latin American Meeting on Public Sector Providers of Legal Abortion, Buenos Aires, Argentina, August 2016 (invited talk).

National

Participation in panel entitled Abortion Scholarship: An Interdisciplinary Conversation, at UC Berkeley Symposium Speech, Symbols, and Substantial Obstacles: The Doing and "Undue"ing of Abortion Law since Casey, Berkeley, 2013 (invited talk).

Impact of restrictive abortion law on women in Texas. North American Forum on Family Planning, Seattle, 2013 (oral presentation).

Randomized Trial of Misoprostol versus Laminaria before Dilation and Evacuation in South Africa. Annual meeting of the National Abortion Federation, San Francisco, 2014 (oral presentation).

Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. Annual meeting of the National Abortion Federation, Baltimore, April 2015 (oral presentation).

Knowledge, opinion and experience related to abortion self-induction in Texas (oral abstract), and participant in panel "Addressing the global need for safe abortion after the first trimester." North American Forum on Family Planning, Chicago, November 2015 (oral presentations).

Participant in panel "Addressing the Challenges Facing Women's Reproductive Health Care," Academy Health National Health Policy Conference, Washington, DC, February 2, 2016 (invited talk).

Panel presentations entitled "Medical abortion restrictions: From label laws to abortion reversal," "Texas: Ground Zero in the Abortion Wars" and "Stolen Lives: Impact of early adolescent pregnancy on all aspects of health," Annual meeting of the National Abortion Federation, Austin, Texas, April 2016.

Panel presentations entitled "Evaluating Reproductive Health Policy at the State Level" and "Translating research into policy: Contributing data to the public debate when it matters most," North American Forum on Family Planning, Denver, November 2016.

Panel presentation entitled "Abortion Outside the Clinic: Imagining Safe and Legal Abortion in a post-Roe World," Physicians for Reproductive Health Grand Rounds, New York University School of Law, New York, March 2017.

<u>Regional and other invited presentations</u>

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2013.

Improving access to early medical abortion through the use of telemedicine. Office of Population Research seminar, Princeton University, 2014 (invited talk).

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Georgia, February 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Baylor University School of Medicine, Houston, Texas, April 2015.

The causes and consequences of unintended pregnancy among women in the US military. San Francisco General Hospital grand rounds, September 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, New Mexico, October 2015.

Using evidence and advocacy to improve second-trimester abortion care in South Africa. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, December 2015.

UCSF/UCH Consortium Annual Supreme Court Review, panel speaker on Whole Woman's Health v. Hellerstedt, San Francisco, July 2016.

American Gynecological Club meeting, presentation on Reproductive Health in Texas and panel participant, San Francisco, September 2016.

Speaking science to the Court: the experience of experts in Whole Woman's Health v. Hellerstedt, panel participant, UC Hastings, San Francisco, October 2016.

How data made the difference in the Texas abortion case before the US Supreme Court. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2016.

Research That Gets Results: A Symposium on Science-Driven Policy Change, panel participant, UCSF, March 2017.

OTHER PROFESSIONAL SERVICE

2007	Member of the International Planned Parenthood Federation Safe Abortion Action Fund Technical Review Panel
2007-2009	Steering committee member of the California Microbicide Initiative
2002-2004	Member, Medical Development Team, Marie Stopes International (London)
2013-Present:	Reviewer of fellows' research proposals for the Fellowship in Family Planning
2013-2015	Member of working group on Guidelines for Task Shifting in Abortion Provision convened by World Health Organization
2014	Discovery working group member, Preterm Birth Initiative (PTBi), UCSF
2013-Present	Board member and Secretary (2014-2016), NARAL Pro-Choice America Foundation
2014-Present	Board member, NAF

TEACHING

FORMAL SCHEDULED CLASSES:

Qtr	Academic Yr	Institution Course Title	Teaching Contribution	Class Size
W	2008-09	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	22
W	2009-10	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	17
F	2014-15	UCSF Coursera course; Abortion: Quality Care and Public Health Implications	Lecturer; 4 lectures	6,000+ (online)
F	2015-16	University of Texas at Austin; Sociology--Reproductive Health and Population in Texas; SS 301 Honors Social Science	Lecturer; 1 lecture	20
S	2016-17	UC Berkeley School of Law; 224.6 - Selected Topics in Reproductive Justice	Lecturer; 1 lecture	12

POSTGRADUATE and OTHER COURSES

Guest lecturer in "Qualitative Research Methods in Public Health," CUNY School of Public Health, September 2011

Women's health from a global perspective. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2007.

TEACHING AIDS

Contributed to the development of a training slide set on medical abortion in Spanish, 2004

Developed pocket cards on emergency contraception for use by community health workers in the State of Mexico, 2005

Reviewed and provided input on a manual on gynecologic uses of misoprostol published by the Latin American Federation of Obstetric and Gynecologic Societies (FLASOG), 2005

Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005. Exerpt available at: http://www.rhlibrary.com/Commentaries/htm/Dgcom.htm.

Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

RESEARCH AND CREATIVE ACTIVITIES

PEER REVIEWED PUBLICATIONS

1. Laudon M, Grossman DA, Ben-Jonathan N. Prolactin-releasing factor: cellular origin in the intermediate lobe of the pituitary. Endocrinology 1990; 126(6):3185-92.
2. Grossman DA, Witham ND, Burr DH, Lesmana M, Rubin FA, Schoolnik GK, Parsonnet J. Flagellar serotypes of Salmonella typhi in Indonesia: relationships among motility, invasiveness, and clinical illness. Journal of Infectious Diseases 1995; 171(1):212-6.
3. MacIsaac L, Grossman D, Balistreri E, Darney P. A randomized controlled trial of laminaria, oral misoprostol, and vaginal misoprostol before abortion. Obstetrics and Gynecology 1999; 93(5, pt.1):766-770.
4. Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. Obstetrics and Gynecology 2004; 103(4):738-45.
5. Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chávez S. Women's perspectives on medical abortion in Mexico, Colombia, Ecuador and Peru: a qualitative study. Reproductive Health Matters 2005;13(26):75-83.
6. Grossman D, Ellertson C, Abuabara K, Blanchard K. Barriers to contraceptive use present in product labeling and practice guidelines. American Journal Public Health 2006;96(5):791-9.
7. Yeatman SE, Potter JE, Grossman DA. Over-the-counter access, changing WHO guidelines, and the prevalence of contraindicated oral contraceptive use in Mexico. Studies in Family Planning 2006; 37(3):197–204.

8. Pace L, Grossman D, Chavez S, Tavara L, Lara D, Guerrero R. Legal Abortion in Peru: Knowledge, attitudes and practices among a group of physician leaders. Gaceta Medica de Mexico 2006; 142(Supplement 2):91-5.
9. Lara D, Abuabara K, Grossman D, Diaz C. Pharmacy provision of medical abortifacients in a Latin American city. Contraception 2006;74(5):394-9.
10. Tinajeros F, Grossman D, Richmond K, Steele M, Garcia SG, Zegarra L, Revollo R. Diagnostic accuracy of a point-of-care syphilis test when used among pregnant women in Bolivia. Sexually Transmitted Infections 2006;82 Suppl 5:v17-21.
11. Clark W, Gold M, Grossman D, Winikoff B. Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research. Contraception 2007;75:245-50.
12. Garcia SG, Tinajeros F, Revollo R, Yam EA, Richmond K, Díaz-Olavarrieta C, Grossman D. Demonstrating public health at work: A demonstration project of congenital syphilis prevention efforts in Bolivia. Sexually Transmitted Diseases 2007;34(7):S37-S41.
13. Díaz-Olavarrieta C, García SG, Feldman BS, Polis AM, Revollo R, Tinajeros F, Grossman D. Maternal syphilis and intimate partner violence in Bolivia: a gender-based analysis of implications for partner notification and universal screening. Sex Transm Dis 2007;34(7 Suppl):S42-6.
14. Harper CC, Blanchard K, Grossman D, Henderson J, Darney P. Reducing Maternal Mortality due to Abortion: Potential Impact of Misoprostol in Low-resource Settings. International Journal of Gynecology and Obstetrics 2007;98:66-9.
15. Grossman D, Berdichevsky K, Larrea F, Beltran J. Accuracy of a semi-quantitative urine pregnancy test compared to serum beta-hCG measurement: a possible tool to rule-out ongoing pregnancy after medication abortion. Contraception 2007;76(2):101-4.
16. Lara D, van Dijk M, Garcia S, Grossman D. La introducción de la anticoncepción de emergencia en la norma oficial mexicana de planificación familiar (The introduction of emergency contraception into the official Mexican family planning norms). Gaceta Médica de México 2007;143(6): 483-7.
17. Grossman D, Blanchard K, Blumenthal P. Complications after second trimester surgical and medical abortion. Reproductive Health Matters 2008;16(31 Supplement):173-82.
18. Grossman D, Fernandez L, Hopkins K, Amastae J, Garcia SG, Potter JE. Accuracy of self-screening for contraindications to combined oral contraceptive use. Obstetrics and Gynecology 2008; 112(3):572-8.
19. Grossman D. Should the oral contraceptive pill be available without prescription? Yes. British Medical Journal 2008;337:a3044.
20. Levin C, Grossman D, Berdichevsky K, Diaz C, Aracena B, Garcia S, Goodyear L. Exploring the economic consequences of unsafe abortion: implications for the costs of service provision in Mexico City. Reproductive Health Matters 2009;17(33):120–132.
21. Hu D, Grossman D, Levin C, Blanchard K, Goldie SJ. Cost-Effectiveness Analysis of Alternative First-Trimester Pregnancy Termination Strategies in Mexico City. BJOG 2009;116:768–779.

22. Távara-Orozco L, Chávez S, Grossman D, Lara D, Blandón MM. Disponibilidad y uso obstétrico del misoprostol en los países de América [Availability and obstetric use of misoprostol in Latin American countries]. Revista Peruana de Ginecologia y Obstetricia 2009;54:253-263.
23. Lara DK, Grossman D, Muñoz J, Rosario S, Gomez B, Garcia SG. Acceptability and use of female condom and diaphragm among sex workers in Dominican Republic: Results from a prospective study. AIDS Education and Prevention 2009;21(6):538-551.
24. Grossman D, Fernandez L, Hopkins K, Amastae J, Potter JE. Perceptions of the safety of oral contraceptives among a predominantly Latina population in Texas. Contraception 2010;81(3):254-60. (NIHMS155993)
25. Potter JE, White K, Hopkins K, Amastae J, Grossman D. Clinic versus Over-the-Counter Access to Oral Contraception: Choices Women Make in El Paso, Texas. American Journal of Public Health 2010;100(6):1130-6. (NIHMS 221745)
26. Phillips K, Grossman D, Weitz T, Trussell J. Bringing evidence to the debate on abortion coverage in health reform legislation: findings from a national survey in the United States. Contraception 2010;82(2):129-30.
27. Hu D, Grossman D, Levin C, Blanchard K, Adanu R, Goldie SJ. Cost-Effectiveness Analysis of Unsafe Abortion and Alternative First-Trimester Pregnancy Termination Strategies in Nigeria and Ghana. African Journal of Reproductive Health 2010;14(2)85-103.
28. Grossman D, Holt K, Peña M, Veatch M, Gold M. Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36):136–146.
29. Grossman D, Grindlay K. Alternatives to ultrasound for follow-up after medication abortion: A systematic review. Contraception 2011;83(6):504-10.
30. Liang S-Y, Grossman D, Phillips K. Women's out-of-pocket expenditures and dispensing patterns for oral contraceptive pills between 1996 and 2006. Contraception 2011;83(6):528-36.
31. Blanchard K, Bostrom A, Montgomery E, van der Straten A, Lince N, de Bruyn G, Grossman D, Chipato T, Ranjee G, Padian N. Contraception use and effectiveness among women in a trial of the diaphragm for HIV prevention. Contraception 2011;83(6):556-63.
32. Grossman D, White K, Hopkins K, Amastae J, Shedlin M, Potter JE. Contraindications to Combined Oral Contraceptives Among Over-the-Counter versus Prescription Users. Obstet Gynecol 2011;117(3):558–65.
33. Potter JE, McKinnon S, Hopkins K, Amastae J, Shedlin MG, Powers DA, Grossman D. Continuation of prescribed compared with over-the-counter oral contraceptives. Obstet Gynecol 2011;117(3):551–7.
34. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the US military: Voices from women deployed overseas. Women's Health Issues 2011;21(4):259-64.
35. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. Obstetrics and Gynecology 2011;118(2 Pt 1):296-303.
36. Holt K, Grindlay K, Taskier M, Grossman D. Unintended pregnancy and contraceptive use among women in the US military: A systematic literature review. Military Medicine 2011;176(9):1056-64.

37. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. Int J Gynaecol Obstet 2011;115(1):77-9.
38. Grossman D, Constant D, Lince N, Alblas M, Blanchard K, Harries J. Surgical and medical second trimester abortion in South Africa: a cross-sectional study. BMC Health Serv Res. 2011;11(1):224.
39. Harries J, Lince N, Constant C, Hargey A, Grossman D. The challenges of offering public second trimester abortion services in South Africa: Health care providers' perspectives. Journal of Biosocial Science 2011;17:1-12.
40. Dennis A, Grossman D. Barriers to Contraception and Interest in Over-the-Counter Access Among Low-Income Women: A Qualitative Study. Perspect Sex Reprod Health 2012;44(2):84-91.
41. Foster DG, Higgins J, Karasek D, Ma S, Grossman D. Attitudes toward unprotected intercourse and risk of pregnancy among women seeking abortion. Women's Health Issues 2012;22(2):e149-55.
42. Foster DG, Karasek D, Grossman D, Darney P, Schwarz EB. Interest in using intrauterine contraception when the option of self-removal is provided. Contraception 2012;85(3):257-62.
43. White K, Potter JE, Hopkins K, Fernández L, Amastae J, Grossman D. Contraindications To Progestin-Only Oral Contraceptive Pills Among Reproductive Aged Women. Contraception 2012;86(3):199-203.
44. Harrington EK, Newmann SJ, Onono M, Schwartz KD, Bukusi EA, Cohen C, Grossman D. Fertility intentions and interest in integrated family planning services among HIV-infected women in Nyanza Province, Kenya: a qualitative study. Infectious Diseases in Obstetrics and Gynecology 2012;2012, Article ID 809682. doi:10.1155/2012/809682.
45. Lessard L, Karasek D, Ma S, Darney P, Deardorff J, Lahiff M, Grossman D, Foster DG. Contraceptive features preferred by women at high risk of unintended pregnancy. Perspectives on Sexual and Reproductive Health 2012;44(3):194-200.
46. Grossman D, Garcia S, Kingston J, Schweikert S. Mexican women seeking safe abortion services in San Diego, California. Health Care Women Int 2012;33(11):1060-9.
47. Hopkins K, Grossman D, White K, Amastae J, Potter JE. Reproductive health preventive screening among clinic vs. over-the-counter oral contraceptive users. Contraception 2012;86(4):376-82.
48. Potter JE, White K, Hopkins K, McKinnon S, Shedlin MG, Amastae J, Grossman D. Frustrated Demand for Sterilization among Low-Income Latinas in El Paso, Texas. Perspectives on Sexual and Reproductive Health 2012;44(4):228–235.
49. White K, Grossman D, Hopkins K, Potter JE. Cutting family planning in Texas. N Engl J Med 2012;367(13):1179-81.
50. Liang S-Y, Grossman D, Phillips K. User characteristics and out-of-pocket expenditures for progestin-only versus combined oral contraceptives. Contraception 2012;86(6):666-72.
51. Manski R, Dennis A, Blanchard K, Lince N, Grossman D. Bolstering the Evidence Base for Integrating Abortion and HIV Care: A Literature Review. AIDS Research and Treatment 2012 (2012), Article ID 802389. doi:10.1155/2012/802389.
52. Schwarz EB, Burch EJ, Parisi SM, Tebb KP, Grossman D, Mehrotra A, Gonzales R. Computer-assisted provision of hormonal contraception in acute care settings. Contraception 2013;87(2):242-50.

53. Grindlay K, Grossman D. Contraception access and use among U.S. servicewomen during deployment. Contraception 2013;87(2):162-9.
54. Grossman D, Grindlay K, Buchacker T, Potter JE, Schmertmann CP. Changes in service delivery patterns after introducing telemedicine provision of medical abortion in Iowa. Am J Public Health 2013;103(1):73-78.
55. Potter JE, Stevenson AJ, White K, Hopkins K, Grossman D. Hospital variation in postpartum tubal sterilization rates in California and Texas. Obstetrics and Gynecology 2013;121(1):152-8.
56. Grindlay K, Grossman D. Unintended Pregnancy Among Active Duty Women in the United States Military, 2008. Obstetrics and Gynecology 2013;121(2 Pt 1):241-6.
57. Hyman A, Blanchard K, Coeytaux F, Grossman D, Teixeira A. Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. Contraception 2013;87(2):128-30.
58. Grindlay K, Grossman D, Lane K. Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study. Women's Health Issues 2013;23(2):e117-22.
59. Shedlin M, Amastae J, Potter J, Hopkins K, Grossman D. Knowledge & Beliefs about Reproductive Anatomy and Physiology among Mexican-Origin Women in the U.S.: Implications for Effective Oral Contraceptive Use. Cult Health Sex 2013;15(4):466-79.
60. Newmann SJ, Mishra K, Onono M, Bukusi E, Cohen CR, Gage O, Odeny R, Schwartz KD, Grossman D. Providers' perspectives on provision of family planning to HIV-positive individuals in HIV care in Nyanza Province, Kenya. AIDS Research and Treatment 2013;2013, Article ID 915923. http://dx.doi.org/10.1155/2013/915923.
61. Steinfeld R, Newmann SJ, Onono M, Cohen CR, Bukusi E, Grossman D. Overcoming Barriers to Family Planning through Integration: Perspectives of HIV-Positive Men in Nyanza Province, Kenya. AIDS Research and Treatment 2013;2013, Article ID 861983, http://dx.doi.org/10.1155/2013/861983.
62. Henderson JT, Puri M, Blum M, Harper CC, Rana A, Gurung G, Pradhan N, Regmi K, Malla K, Sharma S, Grossman D, Bajracharya L, Satyal I, Acharya S, Lamchhane P, Darney PD. Effects of Abortion Legalization in Nepal, 2001–2010. PLoS ONE 2013;8(5): e64775. doi:10.1371/journal.pone.0064775.
63. Grossman D. Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. Annals of Internal Medicine 2013;158(11):839-40.
64. Committee on Practice Bulletins-Gynecology, American College of Obstetricians and Gynecologists, with Steinauer J, Jackson A, Grossman D. Practice Bulletin No 135: Second-trimester abortion. Obstet Gynecol 2013;121(6):1394-1406.
65. Foster DG, Biggs MA, Grossman D, Schwarz EB. Interest in a pericoital pill among women in family planning and abortion clinics. Contraception 2013;88(1):141-6.
66. White K, Hopkins K, Potter JE, Grossman D. Knowledge and attitudes about long-acting reversible contraception among Latina women who desire sterilization. Women's Health Issues 2013;23(4):e257-e263.
67. Grindlay K, Burns B, Grossman D. Prescription requirements and over-the-counter access to oral contraceptives: A global review. Contraception 2013;88(1):91-6.
68. McIntosh J, Wahlin B, Grindlay K, Batchelder M, Grossman D. Insurance and Access Implications of an Over-the-Counter Switch for a Progestin-Only Pill. Perspectives on Sexual and Reproductive Health 2013;45(3):164-9.

69. Grossman D, Grindlay K, Li R, Potter JE, Trussell J, Blanchard K. Interest in over-the-counter access to oral contraceptives among women in the United States. Contraception 2013;88(4):544-52.
70. Grossman D, Onono M, Newmann SJ, Blat C, Bukusi EA, Shade SB, Steinfeld RL, Cohen CR. Integration of family planning services into HIV care and treatment in Kenya: a cluster-randomized trial. AIDS 2013; 27(Suppl 1):S77-S85.
71. Shade SB, Kevany S, Onono M, Ochieng G, Steinfeld RL, Grossman D, Newmann SJ, Blat C, Bukusi EA, Cohen CR. Cost, Cost-efficiency and Cost-effectiveness of Integrated Family Planning and HIV Services in Nyanza, Kenya. AIDS 2013; 27(Suppl 1):S87-S92.
72. van Dijk MG, Lara Pineda D, Grossman D, Sorhaindo A, García SG. The Female Condom: A Promising but Unavailable Method for Dominican Sex Workers, Their Clients, and Their Partners. Journal of the Association of Nurses in AIDS Care 2013;24(6):521-9.
73. White K, Potter JE, Hopkins K, Amastae J, Grossman D. Hypertension among oral contraceptive users in El Paso, Texas. Journal of Health Care for the Poor and Underserved 2013;24(4):1511-21.
74. Withers M, Dworkin S, Harrington E, Kwena Z, Onono M, Bukusi E, Cohen CR, Grossman D, Newmann SJ. Fertility intentions among HIV-infected, sero-concordant Kenyan couples in Nyanza Province, Kenya. Cult Health Sex 2013;15(10):1175-90.
75. Newmann SJ, Grossman D, Blat C, Onono M, Steinfeld RL, Bukusi EA, Shade SB, Cohen CR. Does integrating family planning into HIV care and treatment impact intention to use contraception? Patient perspectives from HIV-infected individuals in Nyanza Province, Kenya. Int J Gynaecol Obstet 2013;123 Suppl 1:e16-23.
76. Grossman D, Fuentes L. Over-the-counter access to oral contraceptives as a reproductive healthcare strategy. Curr Opin Obstet Gynecol 2013;25(6):500-5.
77. White K, Potter JE, Hopkins K, Grossman D. Variation in postpartum contraceptive method use: Results from the Pregnancy Risk Assessment Monitoring System (PRAMS). Contraception 2014;89(1):57-62.
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LANGUAGES

Fluent in Spanish, conversant in French.